USAWC STRATEGY RESEARCH PROJECT

TRANSFORMING HEALTH SERVICE CAPABILITIES IN THE ARMY RESERVE

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ABSTRACT

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The Chief of the Army Reserves, LTG James R. Helmly in September 2003 provided a plan that addresses the Army Reserve Bridge to Transformation and it is officially called the Federal Reserve Restructuring Initiative. The Federal Reserve Restructuring Initiative is synchronized with the Army's Transformation Campaign Plan and addresses people, readiness and transformation. LTG Helmly identified six imperatives he wants embedded in the transformation of the Reserve Component. The reserve medical community can utilize these six imperatives as a lens to examine transformation. The Six Reserve Component Imperatives are: 1. Reengineer the mobilization process; 2. Transform command and control; 3. Restructure units into a flexible and adaptable force; 4. Improve human resources staff; 5. Build a rotational-based force; and 6. Improve individual support to combatant commanders. The purpose of this strategic research project is to focus on the current transformation guidance, review current transformation initiatives and consider the implications of these imperatives on the health service capabilities in the Army Reserve.

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CURRENT TRANSFORMATION GUIDANCE

LTG Helmly, the Chief of the Army Reserve, has been working hard to bring leadership in the Army Reserves to the realization of the importance of change – he calls it 'profound change.'

In October 2004 he stated "the Army Reserves has embarked on a journey of change … the deepest, most profound change it has pursued in more than 50 years. This change revolves around readiness … not the type of readiness reported on a Unit Status Report, but the type of readiness with which our forces will defeat the enemies of our nation… real readiness of soldiers and the institution."[1] This change is part of a formal transformation process occurring throughout the Department of Defense (DoD). In accordance with the Transformation Campaign Plan it is important to understand that "transformation is a process, not an end state"[2]and that "transformation is not a goal for tomorrow; it is a fundamentally important endeavor that we must embrace in earnest today. [3] The military definition of transformation states "transformation is a process that shapes the changing nature of military competition and cooperation through new combinations of concepts, capabilities, people and organizations."[4] The synchronization of transformation in the Reserve Component to that of the Army and other components supports the military definition of transformation. The Army Reserve medical community is undergoing profound change to meet the goals and objectives of transformation. Dr. Robert Murphy, PhD. at the of the Department of Command, Leadership and Management U.S. Army War College states, "Organizational change is a two-step process because two realities exist when addressing organizational change. First, 'What do we change?' and second, 'How do we change?'

In September 2003, LTG Helmly provided six imperatives that address 'What do we change?' The purpose of this strategic research project is to focus on the current transformation guidance, review current transformation initiatives using the six imperatives and consider the implications of these imperatives on health service capabilities in the Army Reserve.

CURRENT TRANSFORMATION INITIATIVES

REENGINEER THE MOBILIZATION PROCESS

"The first imperative changes the existing mobilization process to match the Active Component deployment process, which is 'train-alert-deploy.'[5] Army Reserve units will complete

administrative, medical, logistical and training requirements prior to receiving the alert to mobilize. Army Reserve leadership anticipates the achievement of this new mobilization model will reduce the time necessary to deploy a ready and relevant unit to the combatant commander."[6] Today, mobilization occurs under the concept of graduated mobilization response, and is a tool provided to the President and Secretary of Defense to respond in varying degrees to crises as they occur."[7] Recent Defense Authorization Legislation[8] modified the stated purpose of the Reserve Component mission "to provide trained units and individuals to be available to serve on active duty at any time there is a shortage of active duty personnel."

A reengineering of the mobilization process will involve a review of the responsibilities the Army Reserve medical community will need to support pre and post mobilization medical readiness. The medical community has two distinct requirements in reengineering the mobilization process. First, medical units and personnel have to increase readiness in order to respond as directed under the train-alert-deploy model. Second, the Reserve Component must be able to provide medical readiness screening and health service support at mobilization platforms.

The Army Reserve medical community has a unique requirement to provide continuous support to the ongoing mobilization process. The Army Reserve medical force will have to be structured to support continuous mobilization missions and the readiness of their own medical units. The directive to achieve shortened mobilization timelines is now a part of Reserve Component training guidance.

LTG Helmly's post-mobilization guidance is equally demanding: "Post-Mobilization Training: Post-Mobilization Training requirements must be minimized, with all major training events conducted in a pre-mobilization status. We must reduce post-mob requirements by validation of critical unit tasks and completing COE specific training before mobilization. Soldiers must expect to mobilize for six to twelve months every five years of service. Mobilization is no longer a major event; but, rather, a duty status change… I intend to reduce the average Post-Mobilization Training down to 3-5 days."[9]

Current training guidance must be implemented in earnest because readiness is the key to streamlining mobilization.

TRANSFORM COMMAND AND CONTROL

"The second imperative seeks to create a command and control structure that produces ready soldiers and units."[10] The Army Reserve Medical Command (AR-MEDCOM) is a newly created command that signals a forward leap in the transformation of medical capabilities

embedded in the Army Reserve. LTG Helmly assigned this mission to AR-MEDCOM, directing this Command to exercise command and control of all Army Reserve Medical units and soldiers and to prepare them to rapidly respond to any contingency at home or abroad across the full spectrum of operations. The history and background of AR-MEDCOM derives from six imperatives of the Federal Reserve Restructuring Initiative (FRRI) and was provisionally established by the Chief, Army Reserve on 7 August 2003.[11]

The Army Reserve Medical Command's mission supports three major objectives: to consolidate and centrally manage all Army Reserve AMEDD units and Soldiers; to enhance soldier readiness, medical support, medical training and mobilization timelines; and seamlessly synchronize and align with U.S. Army Medical Command and the Office of the Surgeon General. In order to support these objectives a unique organizational structure was integrated into this functional command. The Commander of AR-MEDCOM will share responsibility as the Deputy Surgeon General (Reserve Affairs). Additionally, a number of major supporting commands (MSC's) will report directly to AR-MEDCOM. There will be a command for training; a professional management command for Human Resources; and regional commands will align with Active Component counterparts to provide command and control.

AR-MEDCOM will provide resources to subordinate units and focus on training, readiness, and mobilization. AR-MEDCOM has a national scope of responsibility to include OCONUS, and will synchronize missions of MEDCOM and the Office of the Surgeon General (OTSG). This synchronization begins with the proponent (OTSG) for policy integration and ends at the lowest level of command.[12]

AR-MEDCOM's areas of interest link with key agencies to ensure integration between the Active Component and the Reserve Component: Forces Command (FORSCOM); United States Army Reserve Command; United States Medical Command (MEDCOM); The Regional Medical Commands (RMC's); Office of the Surgeon General (OTSG), Human Resources Command (HRC); Office Chief of the Army Reserve (OCAR) and AMEDD Center and School.

The Commander of the USARC, LTG Helmly, and the Commander of USMEDCOM, LTG Kiley do share strategic responsibility to provide health service support throughout the world. As strategic leaders "they must concern themselves with the total environment in which the Army functions; establish force structure, allocate resources, communicate strategic vision and mission, and prepare their commands and the Army as a whole for their future roles."[13]

AR- MEDCOM is the control element for all reserve medical resources and provides a mechanism to drive transformation throughout its command. AR-MEDCOM is a new organization that has an opportunity to "create a new game with new rules and develop a

corporate strategy for innovation.[14] This new command will focus the Army Reserve health service capabilities and provide the opportunity to begin transforming how we do business: transforming how we work with others and how we support the fight.

The organization of AR-MEDCOM has synchronized its staff with the active force medical staff. A comparative model of command and control consolidation is the one-staff configuration that was implemented in the Active Component "in 1998, when the Surgeon General directed the implementation of the One Staff concept, by consolidating the staffs at OTSG and Headquarters USAMEDCOM, Fort Sam Houston, Texas. The personnel at both locations function as a single staff with one set of leaders who coordinate Army Staff functions and the Major Army Command functions. The One Staff concept reduced manning requirements by 300 positions, a 40 percent reduction from the prior organizations."[15]

AR-MEDCOM's mission supports and complements the mission of the Active Component Army Medical Department (AMEDD). The mission of the Active Component medical command is to project and sustain a healthy and medically protected force; ensure our military forces are deployed in a state of optimal health and equipped to protect themselves from disease and injury; deploy a trained and equipped medical force that supports the Army Transformation; ensure our deploying medical units are trained and equipped; support the medical requirements of the deployed forces under any contingency; manage the care of the soldier and their military family and provide quality, accessible, cost-effective health services. [16]

The synchronized staffs of the Active Component and Reserve Component will be more effective in supporting Force Health Protection requirements. Force Health Protection (FHP) enables the Department of Defense to equitably support health service requirements. The establishment of a Joint Medical Command is currently in the planning stages. The Joint Medical Command will focus on streamlining health service capabilities in the Future Force and create a command and control structure that overseas Force Health Protection to produce ready soldiers and units throughout the Department of Defense.

RESTRUCTURE UNITS

"The third imperative addresses how to best structure the number, type and composition of units in the Army Reserve."[17]

The Army Reserve must transform to support Total Army requirements. The goal of the reserves is to be a flexible and adaptable force that meets anticipated mission requirements with allotted resources. A close review of unit structure is needed to scrutinize and divest structure that is irrelevant, habitually unready or too costly to modernize.[18] The ability to

anticipate the types of structure the reserve medical community will require to complement future land force missions has been the charter of the Medical Reengineering Initiative (MRI). The Army Reserve medical unit's structure is a product of the Department of the Army Force Integration Office - Medical Reengineering Department.

> The AMEDD continues to implement MRI and, hence, continues its transformation. It is clear that MRI is the spearhead of AMEDD transformation and the bridge to future medical forces along the same single axis of the evolving Army transformation. The MRI linkage to modularity and other Army Focus areas is inextricable…The chartered mission of the MRI program implementation office is to provide Department of the Army staff oversight to the force integration efforts and program management functions of converting the Army's Echelons above Division and Echelons above corps combat health support units from the Medical Force 2000, (MF2K) structure to the MRI Force, and design update.[19]

They manage this conversion process by minimizing turbulence in the force while maintaining unit readiness.

The MRI Force Design Update, approved by the VCSA in 1996, stemmed from lessons learned during the Gulf War. Equipment sets were reduced by $200 million, and two years later a Tiger Team reviewed and refined the Tables of Organization and Equipment (TOE) to maximize efficiency. The U.S. Army III Corps served as the initial test bed for the MRI following Mini Pom FY 01-FY05. The first MRI units were converted or activated in FY2000 in FORSCOM and EUSA. Since that time, more than 79 units have converted to MRI structure.

"The focus of MRI advances the current and future force in the areas of networked warfare, strategic responsiveness and the ability to deploy tailored in modular packages–internal and external to Army formations." [20]

The Adaptive Medical Increments (AMI) organizational structure of the MRI Corps hospital is evolving to take the place of MRI. This new initiative, AMI, provides even more modularity, and the right increments of capability to support future mission requirements.

The U.S. Army Force Management Support Agency (USAFMSA) is in the process of preparing Out-of-Cycle (OOC) MTOE documents that will convert existing MRI Corps Combat Support Hospitals to the AMI organization. "The Army Structure Message is now published and lists the AMEDD structure for Fiscal years 2006-2011. The Army Reserve stands to lose six TOE hospitals. USARC has followed with its structure message.[21]

"The Army Medical Department (AMEDD) has proven its effectiveness on today's battlefield, but there is another equally important change occurring in the AMEDD that affects the way the Army Reserve Medical Units will train. The Active Component is transforming its existing Regional Medical Commands into multi-component, multi-focused, modular, medical

headquarters – The regional Medical Deployment Support Command (MDSC). The MDSC will have the capability to manage regional healthcare facilities, provide uninterrupted healthcare for all beneficiaries, integrate Reserve Component units and individuals, respond to homeland defense and other contingencies, and provide medical support to mobilizing and deploying units. The MDSC will also exercise technical directive authority over active and reserve medical units, continually assessing their clinical and medical logistics mission readiness. What is being proposed could be pejoratively called a 'stovepipe.' However, it is more accurately a 'lifeline.' The AC/RC synchronization occurring at the MDSC assists transformation. The organizational changes should take affect with minimal impact on readiness and the current operations.[22] The necessity exists for both the Active Component and Reserve Component to understand that the mission requirements are now one in the same.

IMPROVE HUMAN RESOURCE MANAGEMENT

> The fourth imperative seeks to improve the management of the Army Reserve human resources lifecycle. The field operating command that has the responsibility to improve human resources is the U.S. Army Human Resources Command (HRC) which combined the U.S. Total Army Personnel Command and the U.S. Army Reserve Personnel Command. The U.S. Army Human Resources Command (HRC) resulted from Army leadership's vision to streamline headquarters, create more agile and responsive staffs, reduce layers of review and approval, focus on mission and transform the Army. HRC's activation is the first step in consolidating personnel services throughout the Army.
>
> As a field operating agency under the Army's G-1, formerly the Deputy Chief of Staff for Personnel, HRC is at the center of the Army's initiative to mold personnel functions into a corporate structure, enabling efficient and effective management of active duty and Army Reserve soldiers worldwide.
>
> HRC integrates and coordinates military personnel systems to develop and optimize the utilization of the Army's human resources in peace and war. HRC also performs all personnel management functions for the distribution, development, retention and transition of active duty soldiers, mobilized Reserve Component soldiers, and those on extended tours of active duty, temporary tours of active duty, or retired recalled to active duty. [23]

HRC - St Louis has Personnel Regional Teams that assist in personnel readiness requirements. Unfortunately, to date personnel management requires extensive management overhead simply to maintain a quality lifecycle management program. The career guidance provided to the health care profession is an invaluable tool in the retention of valued officers and enlisted members of the USAR AMEDD.

Human resource management is the profession of taking care of people on an individual basis. In order to provide the best life cycle management requires a professional organization

that focuses on the individual. The Reserve Component established the AMEDD Professional Management Command that provides the centralized personnel management of all medical professionals to ensure readiness. Within this command are highly specialized detachments that will manage the medical professionals of the Army Reserve. The 1st Medical Detachment is responsible for managing educational delay and the incentives programs. The 2nd Medical Detachment is the National AMEDD Augmentation Detachment that will manage those officers who have incurred a contractual obligation. The 3rd Detachment is the Army Reserve Centralized Credentialing Affairs Office who has the responsibility for maintaining and enforcing health care provider's credentialing.

HR management improves staff technologies and business practices, and assists commanders and leaders at all levels to recruit, develop, train and care for soldiers, families, civilians and contractors.[24] HRC - St Louis and the Personnel Regional Teams need to be embedded in the daily business practices of the personnel officer and the unit administrator. The focus is to improve human resources management and not compete – roles and missions have to be clarified.

This is a key ingredient to the success of medical capabilities in the Army Reserve. The cost of recruiting, training and retaining a health professional is half the battle. The highly sought after skills of the health professional causes the Army Reserve to compete with the private sector and with the limited personal time medical professionals have to sacrifice.

An example of how the reserve medical commander interacts with human resources was stated by a doctor after his return from deployment.

> Requests have been made for additional staff members and resources at all levels. As the medical needs facing the military have increased, however, the supply of medical personnel has gotten tighter. Many surgeons have been on a second deployment or an extended deployment, and even this has not been sufficient. As a result, military urologists, plastic surgeons, and cardiothoracic surgeons have been tasked to fill some general surgeon positions. Planners are having to contemplate pressing surgeons into yet a third deployment. Compounding the difficulties, none of these realities have made it appealing to sign up as a military surgeon. Interest in joining the reserves has dropped precipitously. President George W. Bush has flatly declared that there will be no draft. However, the Selective Service, the U.S. agency that maintains draft preparations in case of a national emergency, has recently updated a plan to allow the rapid registration of 3.4 million health care workers 18 to 44 years of age. The Department of Defense has indicated that it will rely on improved financial incentives to attract more medical professionals. Whether this strategy can succeed remains unknown. The pay has never been competitive. One now faces a near-certain likelihood of leaving one's family for duty overseas. And without question, the work is dangerous.

> The nation's military surgical teams are under tremendous pressure, but they have performed remarkably in this war. They have transformed the strategy for the treatment of war casualties. They have saved the lives of an unprecedented 90 percent of the soldiers wounded in battle. And they have done so under extraordinarily difficult conditions and with heroic personal sacrifices. [25]

The greatest personnel crisis occurring in the Army Reserve medical community is the shortage of physicians. A risk assessment of the current situation points to the obvious – the military needs more physicians to maintain the current operational tempo in order to support the global war on terrorism. The HR community and medical planners need to work closely to ensure an equitable balance of deployed physicians. Unfortunately, due to shortages some surgeons are about to deploy on their third rotation.

BUILD A ROTATIONAL BASE

"The fifth imperative resolves to implement a predictable and sustainable rotation based upon depth in capability."[26]

> LTG Helmly said that the legacy force structure lacked 'rotational depth,' because it was equipped to fight a war like Desert Storm and Desert Storm had a beginning and it had an end. Now, we're in a time when war is the norm, not the exception. The future of the Reserve Component lies in the Army Reserve Expeditionary Force. 'This creates a rotation-based force. It establishes a five-year rotation, so that a given unit knows when it's in the rotation where, if something happens, it will be mobilized first… It's a little like the XVIIIth Airborne Corps where they always have one unit ready to deploy, to go wheels up, within 18hrs.
>
> LTG Helmly asked Soldiers in the Army Reserve how often they can mobilize. 'They said every four or five years. Of course that doesn't mean you can't be mobilized somewhere else in the cycle. The goal of the model is to have predictable readiness.' The equipping of units will also be based on the five-year deployment cycle, allowing the Army to pre-position more vehicles and equipment in operational areas, rather than having them tied up in training missions.[27]

The Army Reserve is "transforming to posture for future Army Reserve Expeditionary Force (AREF) operations… this concept supports LTG Helmly's Train-Alert-Deploy model." [28]

Transforming and resetting medical units to support Army Reserve Expeditionary Forces will be somewhat difficult but the planning is ongoing. The Army Reserve includes in this planning the support of a 90 day 'boots on the ground policy' for physicians and nurse anesthetists. The 90 Day Policy causes the physician population to mobilize more often than the rest of the force. Recommend the physician be allowed to select either the 90 Day Policy or deploy with his or her unit once every five years as predicted.

Rotational based units will provide AR-MEDCOM a management tool to prepare the readiness of its units and soldiers to meet the train-alert-deploy expectation. Rotational based units will assist AR-MEDCOM in long range planning to adopt the doctrine supporting joint medical capabilities in Force Health Protection.

"The Department of Defense views all medical capabilities as Force Health Protection (FHP). This is a major doctrinal shift in the care and management of casualties. FHP focuses on delivery of essential care in theater and evacuation to definitive care outside the theater of operations as soon as practical. The theater hospital provides another doctrinal shift. The theater hospitals should be transportable but are not designed to deploy in proximity to the fighting forces. Theatre Hospitals should be deployed to a location near a major transportation hub to allow easy access to evacuation assets. First responders with the warfighters must provide initial essential care; and Forward Resuscitative Surgery, in close proximity to the fighting forces, provides life, limb and eyesight saving surgical procedures to attain clinical stability prior to evacuation to definitive care. The clinically capable joint evacuation system must support movement of casualties from point of injury or illness to essential stabilizing care and early evacuation to definitive care outside the theater of operations."[29]

IMPROVE INDIVIDUAL SUPPORT TO THE COMBATANT COMMANDERS

"The sixth imperative, maximizing individual capabilities, will be a critical enabler of the Army Unit Manning and the Individual Augmentee needs of the combatant commanders. The current Army posture reveals a growing need to establish a capability-based pool of individual soldiers across a range of specialties. These individuals will be readily available and trained for mobilization and deployment as an Individual Augmentee."30

The Individual Augmentee (IA) and the Individual Mobilization Augmentee (IMA) are Reserve Component programs that support this imperative.

"The Individual Augmentee (IA) program is administered by the U.S. Army Reserve Command's (USARC) Army Reserve Augmentation Unit that works with volunteer Army Reserve Soldiers to provide 179-day, 270-day and 365-day individual augmentation tours. Under the IA program, tours are available for Soldiers to serve in Iraq, Afghanistan, Kuwait, Qatar, Djibouti South America, Bosnia, Kosovo and Tampa, Florida. Currently there are more than 5,000 Troop Program Unit Soldiers (TPU) registered with the IA Program. Since October 2003, more than 500 requirements have been filled through this program. The IA Program has become vital in streamlining the process for filling individual mobilization requirements." [31]

The IA program is a volunteer program. Individual Ready Reserve, Individual Mobilization Augmentee and Troop Program Unit Soldiers can volunteer to be an IA. Active Guard Reserve (AGR) soldiers cannot participate in the IA program.

Another initiative created to identify individual capabilities in the Army Reserve is a program that tracks civilian skills of a reserve soldier. An example might be that a registered nurse in a reserve unit is also a computer engineer in his or her civilian job. The reserve soldier is limited to the types of units located near their home so they pick a military career field based on geographic location. The soldier's civilian skill database assists in providing planners another resource to use when looking for a shortage of skills found in the military inventory.

CONCLUSION – IMPLICATION OF IMPERATIVES ON HEALTH SERVICE CAPABILITIES

The transformation to the future force is occurring and it is profound. Medical capabilities within the entire Department of Defense are in the process of transformation. Joint, active, reserve and guard medical capabilities are merging.

The structures of medical units are changing to create modularity. The AMEDD continues to train to the changes - - while at war. AMEDD tactical and institutional support is vital to supporting the force. The environment in which we are transforming is an environment where conflict is the norm. "The challenges we face as a Nation in the 21st Century from global asymmetric threats have never been more evident. Our current national security and military strategies require that we rapidly transform our medical force structure and deployable platforms to be responsive to a full range of joint military operations. Medical care and evacuation crosses from tactical to strategic – Army to Air Force – further and further forward with joint interfaces being more inter-digitized than simple interfaces. Medical modules of other services are being incorporated in Army medical formations both in the 'TDA' and 'TOE' environment. Medical transformation must take full advantage of unique Service strengths, while at the same time, support joint standards, joint doctrine, and joint military operations. This provides essential capabilities to the warfighter regardless of their parent service. We must ensure that the restructuring of integrated medical support can, in a joint context, transition quickly from expeditionary support to the warfighter that is absolutely effective to a campaign quality environment of integrated health support that is also efficient. Innovative changes in medical doctrine, organization and training, as well as advanced technological solutions are enablers to achieve this transformation. "[32]

The strategic importance of this future force will depend on leadership. "Institutional values, stated values, and operating values should be consistent so that they reflect the same

underlying beliefs and assumptions. The greater the difference between what is espoused and what leaders do, the greater the degree of distrust and loss of confidence between the leadership and the led."[33] Keeping the organization focused on LTG Helmly's six imperatives will assist keeping the organization focused on what to transform. The reserve medical community continues to implement these six imperatives: reengineer the mobilization process; transform command and control; restructure units into a flexible and adaptable force; improve human resources staff; build a rotational-based force; and improve individual support to combatant commanders. "Organizational change will be built on the Chief of the Army Reserves six imperatives, building and sustaining a culture based on trust and confidence, vertically and horizontally is a key responsibility of strategic leadership."[34]

Transforming these imperatives in the health service capabilities will take strategic team work. The purpose of the imperatives keeps the team focused on what is transforming. Transformation gives leaders the construct for what to change and challenges the operational imagination to build a future force which optimizes the valuable resources of our militaries capabilities. Leaders are the visionaries who will provide clarity in building future force. Through out the Department of Defense leadership has to seek out and understand transformation and how it affects the entire military community.

The cost of not understanding transformation could result in catastrophic organizational failure. Health Services capabilities already cost the tax payer billions of dollars a year. "The Army Reserve has to change … an army at war must change… Today, the usual measured approach to change will not suffice. Our current Reserve force is engaged in ways we could never forecast and our biggest challenge is changing mindset and culture.[35]

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